State: *District of Columbia* ***Filing Company:*** *Provident American Life and Health Insurance Company*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Life Individual Combined*
Project Name/Number: *Life Individual Combined/A6121515DC - Info.*

Filing at a Glance

Company:	Provident American Life and Health Insurance Company
Product Name:	Life Individual Combined
State:	District of Columbia
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	09/01/2015
SERFF Tr Num:	GRAX-G130227692
SERFF Status:	Closed-APPROVED
State Tr Num:	
State Status:	
Co Tr Num:	A6121515DC - INFO.
Implementation Date Requested:	
Author(s):	SPI GreatAmericanFinancialRes
Reviewer(s):	John Rielley (primary)
Disposition Date:	09/02/2015
Disposition Status:	APPROVED
Implementation Date:	09/02/2015

State: *District of Columbia* ***Filing Company:*** *Provident American Life and Health Insurance Company*

TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Life Individual Combined*
Project Name/Number: *Life Individual Combined/A6121515DC - Info.*

General Information

Project Name: Life Individual Combined
Project Number: A6121515DC - Info.
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: SPI GreatAmericanFinancialRes

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 09/02/2015
State Status Changed:
Created By: SPI GreatAmericanFinancialRes
Corresponding Filing Tracking Number:

Filing Description:

Please accept this letter as notification to your department of Provident American Life and Health Insurance Company's intent to update the above referenced form, which was approved by your department on 02/06/2015, under file number GRAX-G129906174, by moving the department names of Continental General Insurance Company and United Teacher Associates Insurance Company from the Member Life Insurance and Annuity Companies section, to the Administration for Life Insurance and Annuities section. We certify there have been no language changes made to the form itself.

Please note that this informational filing is being submitted for; Manhattan National Life Insurance Company, Continental General Insurance Company, Great American Life Insurance Company, Central Reserve Life Insurance Company, United Teacher Associates Insurance Company, and Loyal American Life Insurance Company, simultaneously under separate cover.

Company and Contact

Filing Contact Information

Will Walker, Compliance Filing Trainee
P. O. Box 5420
Cincinnati, OH 45201-5420
513-723-2735 [Phone] 12735 [Ext]
513-412-1470 [FAX]

Filing Company Information

Provident American Life and Health Insurance Company
11200 Lakeline Blvd, Suite 100
Austin, TX 78717
(512) 451-2224 ext. [Phone]

CoCode: 67903
Group Code: 901
Group Name: Great American Financial Resources, Inc.
FEIN Number: 23-1335885

State of Domicile: Ohio
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*GRAX-G130227692*	***State Tracking #:***		***Company Tracking #:***	*A6121515DC - INFO.*

State:	*District of Columbia*	***Filing Company:***	*Provident American Life and Health Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life Individual Combined*		
Project Name/Number:	*Life Individual Combined/A6121515DC - Info.*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	John Rielley	09/02/2015	09/02/2015

SERFF Tracking #:	*GRAX-G130227692*	***State Tracking #:***		***Company Tracking #:***	*A6121515DC - INFO.*

State:	*District of Columbia*	***Filing Company:***	*Provident American Life and Health Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life Individual Combined*		
Project Name/Number:	*Life Individual Combined/A6121515DC - Info.*		

Disposition

Disposition Date: 09/02/2015
Implementation Date: 09/02/2015
Status: APPROVED

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	PAHLIC - Authorization Letter	APPROVED	Yes
Form	Policy Change Request Form, Part II	APPROVED	Yes

SERFF Tracking #:	*GRAX-G130227692*	***State Tracking #:***		***Company Tracking #:***	*A6121515DC - INFO.*

State:	*District of Columbia*	***Filing Company:***	*Provident American Life and Health Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life Individual Combined*		
Project Name/Number:	*Life Individual Combined/A6121515DC - Info.*		

Form Schedule

Lead Form Number: A6121515DC-1

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	APPROVED 09/02/2015	Policy Change Request Form, Part II	A6121515DC-1	AEF	Revised	*Previous Filing Number:*		53.500	A6121515DC - 1.PDF
						Replaced Form Number:	*A6121515DC*		

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

GREAT AMERICAN INSURANCE GROUP

Member Life Insurance and Annuity Companies:

☐ **Great American Life Insurance Company®**
☐ **Manhattan National Life Insurance Company®**

Administration for Life Insurance and Annuities:

☐ **Loyal American Life Insurance Company®**
☐ **Continental General Insurance Company**
☐ **United Teacher Associates Insurance Company**
☐ **Provident American Life and Health Insurance Company**

Life Products: P.O. Box 5416, Cincinnati, OH 45201-5416

POLICY CHANGE REQUEST, Part II

Name of Insured _____ **Policy Number** _____

Name of Owner _____ **Telephone No. of Owner** _____

Address of Owner _____ **City** _____ **State** _____ **Zip** _____

☐ Reinstate Policy Face Amount Increase $ _____ Child(ren) $ _____

Add Riders: ☐ Children's Term Life Insurance Rider

(Please Print – Complete Form in Full)

Full Name of Insured:	State of Birth	Date of Birth	Age	Sex	Build Ft.	Build In.	Build Lb.*	Present Life Ins.
								$

*If your weight has changed by over 10 lbs., in the last year, indicate amount and reason.

Address:	City:	State:	Zip:
Driver's License No.:	State Issued:	Social Security No.:	
Name of Employer:	Address of Employer:		
Occupation: (Describe and give active duties)			
Do you contemplate changing your occupation?			

Please print full name of all persons proposed for coverage. Show spouse's maiden name in parentheses, if applicable.

Spouse/Other:	State of Birth	Date of Birth	Age	Sex	Build Ft.	Build In.	Build Lb.*	Present Life Ins.
								$

*If weight has changed by over 10 lbs., in the last year, indicate amount and reason.

Address:	City:	State:	Zip:
Driver's License No.:	State Issued:	Social Security No.:	
Name of Employer:	Address of Employer:		
Occupation: (Describe and give active duties)			
Do you contemplate changing your occupation?			

Child 1:	State of Birth	Date of Birth	Age	Sex	Build Ft.	Build In.	Build Lb.*	Present Life Ins.
								$
Child 2:								$

*If your weight has changed by over 10 lbs., in the last year, indicate amount and reason.

Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in aviation activities or hazardous sports avocation or hobbies? ☐ Yes ☐ No (If yes, please explain.)

Has anyone proposed for coverage ever applied for insurance that was declined, postponed, rated, modified, or had any such insurance cancelled or had a renewal premium refused? ☐ Yes ☐ No

Does anyone proposed for coverage have other life insurance? ☐ Yes ☐ No If yes, please provide the following details.

Company	Plan	Amount	ADB	Year Issued

Will this policy replace or change any life insurance that is currently inforce? ☐ Yes ☐ No

SMOKING HABITS:

Have you ever used tobacco or nicotine products in any form? If yes, please describe.

	Proposed Insured	**Spouse/Additional Insured** (Complete for Spouse/ Additional Insured Term Rider)
During the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
During the last 36 months?	☐ Yes ☐ No	☐ Yes ☐ No
Use other form of tobacco? (If "yes", describe.)	☐ Yes ☐ No	☐ Yes ☐ No
	Other: _____	Other: _____

HAS ANYONE PROPOSED FOR COVERAGE:	**Yes**	**No**
1. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?	☐	☐
2. Had in the past five years any motor vehicle violations, including driving while intoxicated, or had your license suspended or revoked?	☐	☐
3. a. Ever filed for bankruptcy?	☐	☐
b. If "yes," has it been discharged? Date of discharge: _____	☐	☐

NONMEDICAL DECLARATIONS – Complete All Questions

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

1. Has anyone proposed for coverage ever been treated for or had:	**Yes**	**No**
a. Impairment of the eyes or ears?	☐	☐
b. Dizziness, fainting, convulsions, headache, paralysis or stroke within the past ten years?	☐	☐
c. Shortness of breath, blood spitting, bronchitis, asthma, emphysema, or chronic respiratory disorder, sleep apnea or other lung disorders within the past ten years?	☐	☐
d. Chest pain, palpitation, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels? (within the past ten years)	☐	☐
e. Jaundice, hepatitis, intestinal bleeding, ulcer, colitis, recurrent indigestion or any other disease of the stomach, intestines, liver, gallbladder or pancreas?	☐	☐
f. Sugar, protein, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate, or reproductive organs?	☐	☐
g. Diabetes, thyroid, or other endocrine disorders?	☐	☐
h. Disorder of the breasts, prostate, or pelvic organs?	☐	☐
i. Neuritis, arthritis, or disorder of the muscles or bones, including the spine, back or joints?	☐	☐
j. Disorder of skin, lymph glands, cyst, tumor or cancer?	☐	☐
k. Anemia or other disorder of the blood?	☐	☐
l. Alcoholism, alcohol or drug abuse or addiction to use of habit-forming drugs?	☐	☐
m. Panic attacks, anxiety, depression, psychological or emotional or physical disorder not listed above?	☐	☐

NONMEDICAL DECLARATIONS (continued)

	Yes	No
2. Has anyone proposed for coverage:		
a. Had a physical checkup, consultation, or surgery within the last five years?	☐	☐
b. Been a patient in a hospital, clinic, or other medical facility within the last five years?	☐	☐
c. Had an electrocardiogram, X-ray, or other diagnostic test within the last five years?	☐	☐
d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	☐	☐
e. Been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?	☐	☐
3. Is anyone proposed for coverage now pregnant? If yes, expected due date: _____	☐	☐
4. Is anyone proposed for coverage now under medical observation or treatment or currently taking any medication other than as stated above?	☐	☐
5. Is anyone proposed for coverage currently taking medication? If "yes," list name, dosage, reason and date last taken. _____	☐	☐

Details of questions answered "Yes"

Name of Person and Question No.	Disease or Injury	No. of attacks, duration	Dates	Results	Name, Address of Physician

I/we have read the above questions and answers, and hereby declare that the answers and statements as written on this Request are complete and true to the best of my/our knowledge and may be relied on by the Company. I/we agree that this Policy Change Request may form a part of any policy issued. I/we further agree that no policy, addition, or change applied for shall in any event become effective unless and until this Policy Change Request is approved at the Administrative Office of the Company and the full premium due is paid during the lifetime of all proposed insureds, as stated in this Request.

Signed _____ Date _____ Signed _____ Date _____
Owner Spouse

Signed _____ Date _____ Signed _____ Date _____
Insured Additional Insured
(Parent or guardian if Insured is under 18)

Witness _____ Approved by _____ Date _____

AUTHORIZATION TO OBTAIN INFORMATION

I/we, the Proposed Insured(s), authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, employer, or pharmacy benefit manager, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, and any other nonmedical information of me or my minor children, to give to Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company or its legal representative or its reinsurers any and all such information. I/we also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me or my minor children. The types of information may include my/our: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatment; (11) other personal information; (12) Motor Vehicle record, and (13) pharmaceutical information. I/we also authorize Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company or their reinsurers, to make a brief report of my protected health information to MIB, Inc.

I/we understand the information obtained by use of the Authorization will be used by Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company and its reinsurers to determine eligibility or continued eligibility for insurance and eligibility for benefits under an existing policy or a policy applied for. The insurance agent, producer or broker may also use the information to help update my/our insurance program. Any information obtained will not be released by Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company to any person or organization EXCEPT to reinsuring companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my/our application, claim, or as may be otherwise lawfully allowed or required or as I/we may further authorize.

I/we know I/we may request to receive a copy of this Authorization. I/we agree a photographic copy of this Authorization shall be as valid as the original. I/we agree this Authorization shall be valid for two and one-half years from the date shown below.

I ACKNOWLEDGE receipt of the Notice to Persons Applying for Insurance and Notice of Disclosure of Information/MIB, Inc. Disclosure and authorize preparation of an investigative consumer report.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signature of Insured _____ Date _____
(Parent or guardian if Insured is under 18)

Signature of Spouse (If Applicable) _____ Date _____

Signature of Additional Insured (If Applicable) _____ Date _____

SERFF Tracking #:	*GRAX-G130227692*	***State Tracking #:***		***Company Tracking #:***	*A6121515DC - INFO.*

State:	*District of Columbia*	***Filing Company:***	*Provident American Life and Health Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Life Individual Combined*		
Project Name/Number:	*Life Individual Combined/A6121515DC - Info.*		

Supporting Document Schedules

Satisfied - Item:	PAHLIC - Authorization Letter
Comments:	
Attachment(s):	PAHLIC Authorization Letters 012215.PDF
Item Status:	APPROVED
Status Date:	09/02/2015

PROVIDENT AMERICAN LIFE &
HEALTH INSURANCE COMPANY | P.O. Box 26580
Austin, TX 78755-0580

January 22, 2015

To Whom It May Concern,

Provident American Life & Health Insurance Company has engaged the services of Great American Life Insurance Company to act on our behalf with respect to filings related to policy forms, regulatory reporting, complaints, agent appointments, supplemental filings, assessments and advertising on annuities, life insurance and long term care products.

Feel free to contact me should you have any questions.

Sincerely,

Brenda W. Hardison

Brenda Hardison W. ESQ, Secretary

Provident American Life & Health Insurance Company